# Is Psychiatry Going Insane?

*A Conversation With Neurologist John Friedberg Who Warns That the New Psychiatry Is More Quackery Than Science*

**by Timothy Beneke**
April 30, 1992 • *Chicago Reader*

In the last 30 years the field of psychiatry has undergone a major paradigm shift. Where we were once taught to look for the root causes of our suffering in the psychodynamics of our childhood, we are now encouraged to look to our genes, or perhaps our neurotransmitters.

For a decade or more readers of the popular press have been besieged by new discoveries revealing the biological sources of a host of psychological difficulties. Depression, phobias, schizophrenia, manic depression, obsessive-compulsive problems, and indeed much of personality itself are increasingly perceived as manifestations of our biology. These days, as the number of Americans who have taken some kind of psychiatric drug reaches into the tens of millions, the line between psychiatry and neurology is becoming even more blurred. A growing number of psychiatry professors are arguing that training in person-to-person psychotherapy should be optional for new psychiatrists.

The mainstream media have been largely uncritical of this trend, and that has left certain questions insufficiently addressed. Does the fact that a medication relieves psychic suffering mean that the primary cause of such suffering is biological? Is there a danger that in viewing states of extreme mental suffering as illnesses we will lose sight of what the experience itself has to teach us and drive the "mentally ill" into deeper alienation? And if psychiatry, from Freud onward, has largely ignored the social causes of human suffering, isn't biopsychiatry, in locating the sources of human suffering in our biochemistry, furthering that tendency? Doesn't it tacitly encourage a passive attitude toward social and political problems–not to mention one's own life?

To grapple with these and other questions, I met with neurologist John Friedberg, a longtime critic of psychiatry. Friedberg initially intended to become a psychiatrist himself, but his experience during rotations in medical school convinced him that psychiatry was scientifically dubious and often oppressive to those it claimed to help.

Friedberg was a French major at Yale, graduated from the University of Rochester medical school in 1971, and completed a residency in neurology at the University of Oregon in 1978. He was certified by the American Board of Psychiatry and Neurology in 1980 and has been in practice as a neurologist in Berkeley, California, for more than a decade. He was one of the

first doctors to protest the use of electroshock, and his 1976 book Shock Treatment Is Not Good for Your Brain documented shock therapy's destructive effects.

At 49, Friedberg is a friendly, open man who seems resolute in his stand against biological psychiatry.

Timothy Beneke: Psychiatry has a history of committing abuses against patients with little objection from the public at large and even less from within the profession. Tens of thousands of people have been turned into zombies through lobotomies. Until relatively recently psychiatrists authoritatively told us that gay men were incapable of intimacy, and as late as 1975 a standard psychiatric text claimed that one girl in a million was a victim of incest, when the true figure is closer to one in five. Given the history of psychiatry, there's good reason to be cautious about accepting the current claim that psychiatry is well on its way to solving our more severe psychological problems through an understanding of our brain chemistry.

John Friedberg: Understanding brain chemistry is one thing, but giving physical treatments for so-called mental illnesses is quite another. If I hear that a psychiatrist is biologically oriented, then I know that's someone I wouldn't refer a patient to, because they're very likely to treat people with psychiatric drugs and electroshock.

We're currently witnessing a resurgence of biopsychiatry, which means more pills, a comeback for electroshock, and even the return of psychosurgery. Psychiatrists today are engaged in long-term drugging with substances whose effects on the brain and nervous system can be quite destructive.

The key point is that "mental illnesses" are still nothing but hypotheses–and giving medical treatments for hypothetical illnesses is quackery. Giving Haldol for schizophrenia is like giving digitalis for heartbreak. There is still no reliable scientific test for any mental illness, because there's nothing to measure. And science is measurement. Of course most biopsychiatrists will tell you that dependable tests are just around the corner.

TB: Your point is that when psychiatrists tell us that depression or schizophrenia is an illness, by any scientific medical standards they are simply wrong.

JF: Exactly. We don't see campaigns to tell us that cancer is an illness, because it's not in question. But we see this all the time with such things as depression and alcoholism. Historically psychiatrists have understood problems in terms of whatever medical discoveries have recently occurred. In 1800, right after the discovery of the circulation of the blood, it was believed that insanity was caused by too much blood in the head. So they treated it with leeching.

In 1900, after we learned about germs and infectious diseases, many doctors thought insanity was caused by infection. A doctor in New Jersey performed 250 operations to cure insanity by removing "focal infection." He took out teeth, tonsils, uterine cervices, seminal

vesicles, and God knows what else. In an issue of the American Journal of Psychiatry published in 1922, he reported a 30 percent death rate from these operations, but said that the survivors had "marvelous results."

What's happening today is that biopsychiatrists are appropriating some very important discoveries in brain chemistry. Most of my fellow neurologists would agree that we know a fair amount about the anatomy, physiology, and chemistry of vision; a moderate amount about speech and motor functions; a little about memory; and almost nothing scientifically solid about personality and behavior. Psychiatrists are extremely reluctant to admit this.

Some psychiatrists still subscribe to the dopamine theory of schizophrenia, a theory that derives from the success of neurologists at understanding and treating Parkinson's disease. Parkinson's is a neurologic condition with clear physical markers that are visible on examination. Patients have a distinctive gait, a three-per-second tremor, a blank stare, and a consistent blink every time you tap the bridge of the nose. Nine out of ten neurologists will agree about the diagnosis based upon these signs. And at autopsy ten out of ten pathologists will agree. You know it's Parkinson's when the substantia nigra, a part of the brain stem, is visibly depigmented, or when you grind up the brain and find too little of the chemical dopamine. When dopamine is provided in the form of medication, the condition improves.

Within no time, psychiatrists started claiming that schizophrenics had too much dopamine. No one has ever successfully proved this, but the theory lingers on. And the irony is that this theory is used as a justification for giving people a class of drugs called neuroleptics, which produce a Parkinsonian syndrome in patients by blocking dopamine. I'm referring to drugs that the public knows as Haldol, Thorazine, Stelazine, Clozaril, and many others.

TB: You said that psychosurgery is making a comeback.

JF: Yes, but let's look at the historical record first. Something like 50,000 lobotomies were carried out in the U.S., mostly in the 40s and 50s. Walter Freeman, the leading promoter of this "treatment," himself did 4,000 of them. He would often use electroshock for anesthesia or sometimes just novocaine. Then he would raise the patient's upper eyelid and drive an ice pick through the thin bone above the eye into the frontal lobes of the brain. Then he'd move his wrist rapidly from side to side and disconnect the frontal lobes from the rest of the brain. Freeman carried an ice pick on his belt and crisscrossed the country visiting state hospitals on what he called head- hunting tours. He did all this with little protest inside or outside of psychiatry.

Last April there was a report out of Stockholm published in the prestigious *Acta Psychiatrica Scandinavia* on 27 cases of "capsulotomy" for neuroses–including anxiety, obsessive- compulsive disorder, and one case of "panic disorder with agoraphobia." A capsulotomy is a brain operation in which depth electrodes burn holes the size of small marbles in the white matter connecting the frontal and temporal lobes. The aim is the exact

same as with lobotomy–to disconnect two parts of the brain, the frontal lobes and the limbic system, which controls emotions.

The study reported 80 percent relief without personality deterioration. The authors also reviewed 350 other capsulotomies–350 "new, improved" lobotomies. That's really frightening.

TB: Let me play devil's advocate. I find biopsychiatry intellectually plausible but politically dangerous. I find it plausible for two reasons. One, I accept the 20th-century scientific worldview that says consciousness is grounded in, dependent on, and caused by the brain. And two, I'm struck by the fact that in so many cases people suffering from psychological problems have been no more abused or stressed than anyone else.

If there were a more or less clear-cut correlation between the amount of abuse and stress people experienced and their degree of psychological suffering, I'd be inclined to believe that biology was not an important factor. But that's not what we find. The most obvious case is the cluster of experiences and behaviors referred to as schizophrenia, where people experience hallucinations and delusions and become emotionally flat and withdrawn. Such people often come from loving and well-off families and have not been abused. It seems reasonable to suppose that the root cause of their problems is neurological and not psychological, even if no marker has been found or if the scientific claims to explain brain chemistry are overstated.

JF: It appears that we do have "crazy" kids coming from "sane" parents. I don't know any better than anyone else how some humans get to be a bit too "random," as they say today. But as a neurologist I was trained to know when unusual conduct is part of a larger picture of neurologic disease and when it is not.

TB: Perhaps the training you received did not allow for enough conceptual fluidity regarding all this.

JF: My standards are those of good science. If someone proves scientifically that there's a brain disease called schizophrenia or manic depression, I'll accept it as I would any other discovery–brain diseases are my specialty. But no one has.

I try to keep it simple. I use two categories: physical disease or no disease. It serves no purpose to deal with three categories: disease/no disease/mental disease. I try to ignore eccentricities and personalities in neurologically evaluating my patients in order to avoid the pitfall of blaming the patient for the symptom and missing something serious. A so-called schizophrenic complaining of headaches may not be taken as seriously as an engineer complaining of headaches.

Also, I have no objective way to test for "mental illness," so why use a stigmatizing label? Calling someone "bipolar" or "dysthymic" doesn't help me, and it certainly doesn't help the person labeled. A psychiatric diagnosis is demoralizing. It also sticks with people for life and

causes problems getting sound medical treatment, getting jobs and driver's licenses, and just getting taken seriously.

In psychiatry diagnosis is a sham. In 1973, in a famous study published in Science called "On Being Sane in Insane Places," eight volunteers got themselves locked up in different psych wards around the country by simply stating that they were hearing sounds. They acted normally otherwise and immediately after admission said that they had stopped hearing the sounds. It took an average of 19 days for them to get out, and some had to retain lawyers to get released!

The Diagnostic and Statistical Manual tells psychiatrists how to determine who has what from more than 300 categories of disorders. A committee meets and votes illnesses in and out: "Everyone on the eating-disorder subcommittee who thinks such and such is a disease, raise your hand." Mental illnesses are constantly being revised and done away with. The whole process ought to make us suspicious. Strokes and epilepsy and even migraines haven't changed since they were first described 3,000 years ago.

TB: What would you do with psychotically depressed people who aren't eating or sleeping?

JF: I'd have to look at the individual case and play it by ear. But one thing I would not do is cause brain damage to add to their problems. The psychiatrist who can come up with nothing better than drugs and shock should probably be in another line of work. Generally, I would recommend exercise and meditation–life-style changes–and patience, among other things. The essence of what is called depression is the feeling that it will never end. Everything ends. Doctors depend on it. We call it "tincture of time."

TB: I realize that anecdotes do not constitute science, but let me tell one anyway. I have a friend who contracted a virus and afterward found himself fatigued and depressed. He began to have trouble sleeping and found it difficult to function in his job. For months he tried to come out of it. He exercised, meditated, tried to gain psychological perspectives on what was going on, played with his diet, and so forth. Nothing worked. He had experienced mild depressions before but had always been able to understand the psychological forces at work on him and come out of it. Finally, he went to a sleep-disorder clinic and was told that they couldn't help him because he was clinically depressed. He went to a biological psychiatrist and was put on a medication. Within a few days he had his first good night's sleep in a year and soon came out of the depression. He was able to finish a major project he was working on and has been thriving for several years now. He went off the drug after a year or two and now looks back on the time he was on it as the highest period of his life.

A couple of things stand out. One, nothing psychological precipitated his depression, and two, something physical–a drug–appears to have cured it. He went through a major shift in his thinking and came to see what he was going through as a biologically caused process.

JF: You said it was preceded by a flulike illness? I hope Lyme disease or other infectious diseases were ruled out.

Assuming your account of what happened is accurate, a drug appeared to have made a big difference to your friend. That doesn't mean that his problem was necessarily a disease. Drugs are often used by healthy people, and this drug helped him sleep. Sleep is a great healer.

I also wouldn't underestimate the effect of a placebo. His faith in the drug may have helped him a lot. Placebos really can reduce pain; they can shorten the duration of colds and make warts disappear. The placebo effect on patients and doctors is exactly why controlled studies are necessary and anecdotes rejected.

But let me make a few points. There is a powerful organization called the National Alliance for the Mentally Ill–NAMI–and the key word is for. The organization is made up mostly of parents of those labeled mentally ill. Like your friend, they find solace in believing that mental illness is biological and genetic. It relieves them of the blame associated with some of the psychological theories of causation. But it does implicate their genes, and resurrects the stigma of "insanity in the family," and implies fatalistic hopelessness. I can't see this as reassuring.

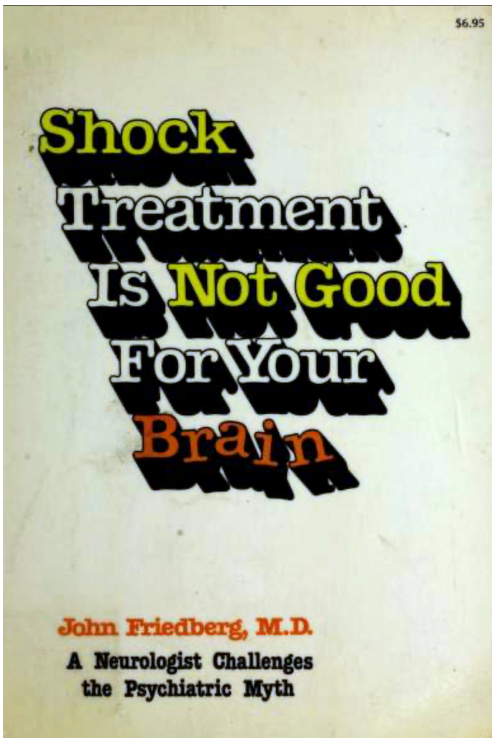
NAMI and biopsychiatry generally promote drugs to correct presumed chemical imbalances. But the idea that you can jump from the molecular level of a drug to the level of behavior prediction and control is wishful thinking, with no scientific basis whatsoever. Just think about alcohol. Can we predict in any single case how it will affect someone? One person will get withdrawn and another aggressive. Another person will be silly and talkative, while another is quiet and sad. Some people are strongly affected, and others hardly at all.

We know very little about the effects of drugs on behavior, and yet the drug companies are constantly trying to convince us otherwise.

TB: However unpredictable their effects, there does appear to be progress in the production of psychiatric drugs. A lot of people in the last three years seem to have had their moods lifted by Prozac, a new antidepressant. And most people are able to learn through experience how a particular drug will affect them.

JF: I have nothing against adults taking drugs. I don't really know what the proper role of mind-altering drugs should be in people's lives. They have been used in every culture and every era, and they certainly can make people feel different.

The issue today is who controls what people put into their bodies and do to their brains. Do people get to choose on their own, or should some authority tell them what drugs to take or not to take? Most psychiatric drugs couldn't compete with recreational drugs in a fair fight. Haldol and lithium have no street value, as far as I know. I find it ironic that our free-enterprise society is waging war on certain psychoactive drugs, while psychiatrists promote others in the name of health. Eli Lilly, who manufactures Prozac, expects to make $1 billion this year on that drug alone. There are 600,000 prescriptions a month.




TB: Critics of biopsychiatry claim that now that there are so many cheaper forms of therapy–by MSWs, clinical psychologists, MFCCs, pastoral counselors, and so forth–that psychiatrists are feeling economically threatened. Psychiatry has always had a legitimation crisis, whether it's within medicine itself, where its scientific credentials are often questioned, or society at large, where it has to compete with religion, among other things. Now it also has to compete with 12-step and other self-help groups that have become more popular. Is biopsychiatry guilty of overstating its claims because it's being economically threatened?

JF: Absolutely. The fight over turf is intense among therapists. Psychiatrists are in a spiritual marketplace that should be wide open. If they can succeed in defining spiritual problems as physical ones, then they've completely excluded everyone but physicians from dealing with these things. If all kinds of human problems can be redefined as genetically based physical illnesses or chemical imbalances, then only doctors should be allowed to treat them.

TB: I'm struck by how terrifying the "mad" are for most of us, and how they confront us with our own irrational sides. There's something very comforting about biological psychiatry. Seeing the behavior of disturbed people as symptomatic of a brain disease is so much more comfortable than trying to relate to these people as people. I wonder to what extent psychiatrists are motivated to assuage their own anxieties about madness by framing it in terms of disease.

JF: Fear of insanity is like the fear of hell–it's a bogus concept that keeps people in line. It gets to medical students and some residents, but most practicing psychiatrists, I would guess, feel immune. That is not to say that some aren't pretty "crazy," but who's going to diagnose them? And who among them would submit to electroshock?

TB: It seems to me that the fact that shock therapy is today a favored treatment for severe depression constitutes a kind of confession of failure on the part of psychiatry. It's like shaking the radio to get it to work. But defenders of shock treatment claim that it has become a relatively benign procedure. They now reduce the voltage, give anesthesia, and shock only one side of the brain–there is now less memory loss than there once was. Proponents argue that shock is the quickest way to bring someone out of severe depression and that given that better than one in seven severely depressed people will commit suicide, shock treatment saves lives. You have been one of its most vocal critics. How do you respond to its resurgence?

JF: With concern and skepticism. The American Psychiatric Association convened a task force in 1990 to examine the safety and benefits of shock treatment. It was composed of very like-minded people, who concluded that it is not only safe and effective but that it is being underutilized. Then about a year ago the Food and Drug Administration announced its intention to down-class the shock machine from "most risky device" to "medium risky." They didn't argue that the devices used today are any safer than the older devices. Instead they argued that the benefits outweigh the risks. Leading advocates–like psychiatrist Max Fink, who edits a journal called Convulsive Therapy–tour the country giving grand rounds and conducting training conferences on electroshock. I saw his presentation at Langley Porter Psychiatric Hospital in the spring of 1990. Shortly after his visit, Langley Porter and two other San Francisco hospitals announced that they would lift the self-imposed decade-long ban on ECT [electroconvulsive therapy] and start giving it again.

There is no "new, improved" electroshock. All the changes you mentioned have been in place for more than 30 years–anesthesia, muscle paralysis, unilateral shock. Anesthesia and muscle paralysis–not "relaxation"–are mostly cosmetic and are associated with additional serious risks. And unilateral shock–shocking one side of the brain–has little significance, because most psychiatrists don't use it. And when they do give unilateral, they give more electrical energy, they get less "improvement," and the brain damage is still demonstrable with special tests such as facial recognition and spatial relations. Due to a neurologic phenomenon known as denial–or anosognosia–the victims often don't even know that something's wrong with them. And the electroshock blots out the memory of what was troubling them. So they don't complain, which some psychiatrists regard as a sign of improvement.

There is something called a seizure threshold which must be reached before a convulsion is triggered. The brain doesn't convulse without good reason. There has to be a significant insult, such as extremely low blood sugar, very high fever, deprivation of oxygen, a concussion–or a shock to the head. For thousands of years seizures were regarded as undesirable, to be prevented if at all possible. The physician's purpose was to strengthen the brain's natural resistance to convulsion, not subvert it.

Max Fink himself compared electroshock to "any other form of head injury." And that's what it is–a way of producing brain damage, the primary symptom of which is memory loss. In animal experiments dealing with memory loss, shock is the method of choice for producing it. The anatomic evidence for brain damage from electroshock is found every time it's seriously sought. Brain-wave tests, EEGs, are slow for up to six months after shock therapy and sometimes show seizure activity kindled by the electricity. Psychometric testing shows memory impairment mostly for personal data immediately preceding ECT, but there's also patchy memory loss often extending much further back. And recently magnetic resonance imaging is showing swelling in the brain after each shock. Shock causes a surge of high blood pressure. It may be that this causes the swelling.

You mention the claim that electroshock somehow prevents suicide, but I have yet to see a prospective study showing this to be the case. Electroshock definitely works in the sense that people look and act differently for a while. Some get euphoric, some get apathetic, dependent, and helpless. Most appear to undergo a change of attitude and become more cooperative. Electricity has a taming effect.

Sometimes electroshock works simply by producing retrograde amnesia. People have always intuitively known that our greatest faculty–our memory–is also a great source of suffering. Many of the ways we cope–from repeating mantras, to repetitive exercise, to drinking ourselves into oblivion–are aimed at blocking out painful thoughts.

We also shouldn't forget just how aversive an electric shock is. Humans and animals hate it. You get a shock and you don't do it again, whatever it was.

TB: The people who receive electroshock tend to be the less powerful members of society.

JF: Right. For a long time twice as many women as men have been getting electroshock. What's new is that now more than half of those who receive it are over 65 years old. The elderly are usually covered by medicare and other insurance, and they're virtually malpractice proof. Many of them, especially the ones living in nursing homes, are politically and socially defenseless. Their reports of memory difficulties are almost automatically blamed on senility.

TB: Where do you see biopsychiatry headed?

JF: Some psychiatry journals read like advanced biochemistry texts. Advances in immunochemistry have been especially rapid, and sometimes it seems we've got more tests than we know what to do with. What is striking about poring over psychiatric journals is how often one study claims to "point the way to a new breakthrough" or "holds great promise" of finally identifying the chemical imbalances behind "mental illness." Yet with all the research, there isn't a single "mental illness" that has made it into a pathology textbook.